SHICK Senior Health Insurance Counseling for Kansas

CONFIDENTIALITY AGREEMENT FOR RECEIPT OF UNIQUE ID

I hereby agree and understand that I am accountable in protection of the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the SHIP unique ID which has been assigned to be by the Centers for Medicare & Medicaid Services. This ID, along with other identifying information will allow a 1-800-MEDICARE Customer Service Representative (CSR) or participating Medicare Advantage or Part D Plan sponsor to disclose certain beneficiary eligibility and claims payment-specific information to me for the purpose of assisting the beneficiary. I further understand this unique ID is to be confidential and I am not to disclose this ID to anyone other than the CSR.

_____
Name (printed)

_____ _____
Counselor Signature Date

_____
Counselor e-mail address

_____ _____
SHIP Director Signature Date

Original to File
Copy to Volunteer

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